Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS MEDICAL TOXICOLOGY
PO BOX 4900
HOUSTON TX 77210

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-13-1390-01

MFDR Date Received
FEBRUARY 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is not a duplicate laboratory billing and is medically necessary, based on Official Disability Guidelines. Please reprocess all, unpaid Lab CPT's correctly."

Amount in Dispute: $506.00

RESPONDENT'S POSITION SUMMARY

Respondent's Summary: Carrier acknowledged DWC-60 on February 12, 2013.

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20, 2012	Urine Drug Screen	$506.00	$319.43

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.210 sets out documentation requirements.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for clinical laboratory services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-16 Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code).

- CAC–97 The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217– The value of this procedure is included in the value of another procedure performed on this date.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 641– The medically unlikely edits (MUE) from CMS has been applied to this procedure code.
- 758– ODG documentation requirements for urine drug testing have not been met.
- 790– This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- CAC-193 Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration.

Issues

1. Did the requestor meet division documentation requirements?
2. Did the carrier appropriately request additional documentation?
3. Were Medicare policies met?
4. Is reimbursement due?

Findings

1. The workers' compensation carrier (carrier) denied services, in part, using claim adjustment code 758 which states that "ODG documentation requirements for urine drug testing have not been met." Documentation requirements for the services provided are not established by ODG, rather, documentation requirements are established by 28 TAC §133.210 which describes the documentation required to be submitted with a medical bill. 28 TAC §133.210 does not require documentation to be submitted with the medical bill for the services in dispute. The carrier's denial reason is not supported.
2. The carrier cites the lack of clarifying information and/or documentation as a reason for denial of payment. The process for a carrier's request of documentation not otherwise required by 28 TAC §133.210 is described in section (d) of that section as follows:

   "Any request by the insurance carrier for additional documentation to process a medical bill shall:
   (1) be in writing;
   (2) be specific to the bill or the bill's related episode of care;
   (3) describe with specificity the clinical and other information to be included in the response;
   (4) be relevant and necessary for the resolution of the bill;
   (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   (6) indicate the specific reason for which the insurance carrier is requesting the information; and
   (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation."

   No documentation was found to support that the carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The division concludes that carrier failed to meet the requirements of 28 TAC 133.210(d).

3. 28 TAC §134.203(b)(1) states that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiative (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." §134.203(a)(5) states that "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, values and weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." The services in dispute are clinical laboratory services; therefore, Medicare policies for the clinical laboratory services must be met. The services in dispute are addressed in the CMS Clinical Laboratory Fee Schedule. The requestor billed the following AMA CPT codes/descriptions as follows:
   - CPT code 82570, one unit creatinine
     .
   - CPT code 82520, one unit cocaine or metabolite

- CPT code 82542, one unit column chromatography/mass spectrometry
- CPT code 82542/59, two unit column chromatography/mass spectrometry, analyte not elsewhere specified
- CPT code 83925, one unit opiate (s) drug and metabolites
- CPT code 83925/59, one unit (three drugs/metabolites) immunoassay of opiates
- CPT code 82649, one unit Dihydromorphinone
- CPT code 82646, one unit Dihydrocodeinone
- CPT code 82646/59, one unit Dihydrocodeinone

Review of the medical bill finds that current AMA CPT codes were billed, and that there are no CCI conflicts, Medicare billing exclusions, or medically unlikely edits (MUE) that apply to the clinical laboratory services in dispute. The requestor met 28 TAC §134.203.

4. The services in dispute are eligible for payment. 28 TAC §134.203(e) states:

"The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and

(2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2012 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. Review of the document finds that the provider sufficiently documented all units billed. Therefore, the total MAR is $319.43 as follows:

- 82570 1 Unit = ($7.33 x 1.25%) x 1 = $9.16
- 82520 1 Units = ($21.47 x 1.25%) x 1= $26.84
- 82542 1 Unit = ($25.57 x 1.25%) x 1 = $31.96
- 82542/59 2 Units = ($25.57 x 1.25%) x 2 = $63.93
- 83925 1 Units = ($27.56x 1.25%) x 1 = $34.45
- 83925/59 1 Units = ($27.56 x 1.25%) x 1 = $34.45
- 82649 1 Units = ($36.41 x 1.25%) x 1= $45.51
- 82646 1 Units = ($29.25 x 1.25%) x 1 = $36.56
- 82646/59 1 Units = ($29.25 x 1.25%) x 1 = $36.56

$319.43

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $319.43.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to $319.43 additional reimbursement for the services involved in this dispute.

Authorized Signature

		May 30, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.